In this space, attach a recent photo, sized approximately 2"by 2", clearly picturing the applicant's face.

(FOR IDENTIFICATION PURPOSES ONLY)

APPLICATION FOR PROVISIONAL LICENSE

Return this completed form, with a check or Money Order for the Provisional License fee of $250, Fingerprint card processing fee $56, Processing fee $25 (Total $331)-(payable to NHAP) to the following address:

Nursing Home Administrator Program
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416

PRINT OR TYPE

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER *

CURRENT ADDRESS *(If PO Box, Must provide street address as well)*

PERMANENT MAILING ADDRESS INCLUDING POSTAL CODE (if different from current address listed above)

BUSINESS MAILING ADDRESS

IDENTIFY PREFERRED PUBLIC RECORD ADDRESS. ☐ Current ☐ Permanent ☐ Business	DAYTIME PHONE	EVENING PHONE
DATE OF BIRTH (MM/DD/YYYY)	E-MAIL(Optional)	FAX(Optional)

* Disclosure of your social security number (SSN) is mandatory. Health and Safety Code, Chapter 2.35, Section 1416.28 authorizes collection of your SSN. If you fail to disclose your SSN, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

ANSWER THE FOLLOWING QUESTIONS:

1. **Are you now, or were you, employed as a Nursing Home Administrator in any other state within the U.S.?** ☐ YES ☐ NO
(If **"YES",** fill in the information below.) (Provide each State with certification on page 5.)

State: _____ License #: _____ Date of Expiration: / /
State: _____ License #: _____ Date of Expiration: / /
State: _____ License #: _____ Date of Expiration: / /
State: _____ License #: _____ Date of Expiration: / /

2. **Former Names?** (If **"YES",** list in space below) ☐ YES ☐ NO

a. _____
b. _____
c. _____

**** CERTIFICATION—IMPORTANT—PLEASE READ BEFORE SIGNING—If not signed, this application may be rejected. ****

I certify under penalty of the perjury laws of the State of California that the information I have entered on this application is true and correct. I further understand that failure to disclose requested information or any false, incomplete, or incorrect statements may result in denial of this Provisional License Application and/or disqualification from State Examination and/or applying through reciprocity with the Nursing Home Administrator Program. I authorize the employers, U.S. State Agencies and educational institutions identified on this application to release any information they may have concerning my licensure, disciplinary records, employment or education to the State of California Nursing Home Administrator Program. ***I understand that the California Provisional License is valid for 12 months only, it is not renewable. I must take and pass the State Examination within the 12-month time frame. I further understand that if I do not pass the examination during that time, I will have to reapply through regular reciprocity procedures with NHAP and I will not be able to continue to work in California without a CA NHA License. I also understand that all the fees are non-refundable.***

APPLICANT'S SIGNATURE **	DATE SIGNED **

APPLICANTS—DO NOT USE THE SPACE BELOW—FOR NHAP USE ONLY

FOR NHAP OFFICE USE ONLY

CASH. # _____	STATUS ☐ Approved ☐ Rejected ☐ Reciprocity ☐ Missing Information

State of California –Department of Health Services

Nursing Home Administrator Program

NHAP INITIALS _____	☐ Correct Fees	☐ State Certifications
AMOUNT _____	☐ Fingerprints / Livescan	☐ Provisional License #
	STAFF	DATE PROCESSED

NHAP PROVISIONAL LICENSE APPLICATION

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER

3. Are you now or have you ever been licensed or certified by any other California State Agency? (If "**YES**", please complete below.)

Agency: _____ License #: _____ Date of Expiration: / /

Agency: _____ License #: _____ Date of Expiration: / /

Agency: _____ License #: _____ Date of Expiration: / /

4. Have you ever pled guilty or nolo contendere to, or been convicted of any crime (other than minor traffic violations)? ☐ YES ☐ NO

IF THE ANSWER TO THIS QUESTION IS YES, EXPLAIN FULLY ON A SHEET OF PAPER. PROVIDE CERTIFIED COPIES OF ARREST REPORT AND COURT DOCUMENTS THAT INCLUDE THE FOLLOWING AS APPLICABLE: CRIMINAL COMPLAINT, PLEA AND JUDGEMENT, AND PROBATION REPORT. IF THESE RECORDS HAVE BEEN DESTROYED, THE PROGRAM REQUIRES A SIGNED STATEMENT TO THAT FACT ON AGENCY LETTERHEAD, FROM THE AGENCY YOU ARE REQUESTING RECORDS. A CONVICTION WILL NOT NECESSARILY DISQUALIFY YOU.

5. Have you ever allowed your NHA license to lapse, or had a temporary license issued by any state licensing authority? ☐ YES ☐ NO

IF YES, IDENTIFY THE STATE AGENCY AND LICENSE NAME AND NUMBER. _____.

6. Have you ever voluntarily surrendered any other professional license? ☐ YES ☐ NO

7. Have you ever been the subject of disciplinary action by any licensing agency with regard to any other professional license? ☐ YES ☐ NO

If **YES**, provide detailed explanation on a separate sheet of paper and attach to application package.

8. Health and Safety Code, Section 1416.38(d),(1) requires each applicant for Provisional License to provide "a statement of health consistent with an ability to perform the duties of a Nursing Home Administrator." Do you meet these requirements? ☐ YES ☐ NO

9. Within the last five(5) years have you had a license or certification revoked or suspended, other disciplinary action taken, or an application for licensure or certification refused, revoked or suspended by any professional licensing authority of another State, Territory or Country? ☐ YES ☐ NO

If YES, identify agency, state, license name and number, and reason. _____.

10. If required because of a subpoena for NHA licensure records, can you provide adequate documentation for any of the answers you provided above? ☐ YES ☐ NO

11. EDUCATION

DID YOU GRADUATE FROM HIGH SCHOOL?	IF NOT, DO YOU POSSESS A GED OR EQUIVALENT?	IF NOT, ENTER THE HIGHEST GRADE YOU COMPLETED
☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	

UNIVERSITY OR COLLEGE NAME--AND LOCATION. BUSINESS, CORRESPONDENCE, TRADE, TECHNICAL, OR SERVICE SCHOOL	**COURSE OF STUDY**	**UNITS COMPLETED**		**DIPLOMA, DEGREE OR CERTIFICATE OBTAINED**	**DATE COMPLETED**
		SEMESTER	**QUARTER**		

12. NURSING HOME WORK EXPERIENCE ***(Licensed NHA's)***

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ YES ☐ NO
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	
DEPT. OF NURSING HOME		FACILITY ADDRESS, CITY, STATE, ZIP	

Check Appropriate Box

☐ I am authorized and have personally verified the information from records on file at the facility.	FROM: / /	TO: / /
☐ I have personal knowledge of this work experience because I worked at the same facility as the applicant.	FROM: / /	TO: / /
**** Signature of Licensed NHA, Physician, or RN** _____	**LIC. #** _____	**DATE:** / /

NHAP PROVISIONAL LICENSE APPLICATION

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER

12. NURSING HOME WORK EXPERIENCE *(Licensed NHA's)*

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ YES ☐ NO
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	
DEPT. OF NURSING HOME		FACILITY ADDRESS, CITY, STATE, ZIP	
DUTIES AND RESPONSIBILITIES			

Check Appropriate Box

☐ I am authorized and have personally verified the information from records on file at the facility.	FROM: / /	TO: / /
☐ I have personal knowledge of this work experience because I worked at the same facility as the applicant.	FROM: / /	TO: / /
**** Signature of Licensed NHA, Physician, or RN** _____	**LIC. #** _____	**DATE:** / /

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ YES ☐ NO
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	
DEPT. OF NURSING HOME		FACILITY ADDRESS, CITY, STATE, ZIP	
DUTIES AND RESPONSIBILITIES			

Check Appropriate Box

☐ I am authorized and have personally verified the information from records on file at the facility.	FROM: / /	TO: / /
☐ I have personal knowledge of this work experience because I worked at the same facility as the applicant.	FROM: / /	TO: / /
**** Signature of Licensed NHA, Physician, or RN** _____	**LIC. #** _____	**DATE:** / /

13. SPECIALIZED TRAINING

List in chronological order, from date of graduation from any professional school or program to the present, all professional post-graduate training not including continuing education coursework (i.e., residency, vocational training, practical or clinical training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (month/year)	DATES OF ATTENDANCE TO (month/year)	DID YOU COMPLETE TRAINING?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

NHAP PROVISIONAL LICENSE APPLICATION

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER

14. CITIZENSHIP *(Health and Safety Code 1416.22(a))*

(a) Are you a United States Citizen? ☐ **YES** ☐ **NO**

(b) Are you at least 18 years of age or older? ☐ **YES** ☐ **NO**

15. FAMILY SUPPORT

In accordance with the Welfare and Institution Code Section 11350.6, applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 calendar days delinquent in complying with a child support order, order for spousal support or alimony repayment obligation. Failure to certify may result in disciplinary or adverse action, and making a false statement may subject the licensee to denial or revocation of provisional license.

You **must** check one of the following:

☐ I am not more than ____ days delinquent in complying with a child support order/order for spousal support or alimony/educational loan repayment obligation.

☐ I am more then ____ days delinquent in complying with a child support order/order for spousal support or alimony/educational loan repayment obligation.

☐ I am current in compliance with a family support order.

☐ I am not currently under any child support order/spousal support or alimony repayment obligation.

16. Do you have a job offer for a NHA position with a nursing home or long-term care facility in the State of California? ☐ **YES** ☐ **NO**

If **YES**, please provide facility and contact information below.

17. TO BE COMPLETED BY FACILITY EMPLOYER

NAME OF APPLICANT *(LAST)*	*(FIRST)*	*(MIDDLE)*

FACILITY PHONE NUMBER	JOB TITLE OFFERED	DATE TO BEGIN

NAME AND ADDRESS OF FACILITY, OFFICE OR CORPORATION

NAME, ADDRESS, AND PHONE NUMBER OF SNF / ICF WHERE JOB WILL BE HELD	DATE / /
CONTACT PERSON AT FACILITY (Name, Title)	PHONE NUMBER:

☐ **I have reviewed the application package and it is complete with the necessary attachments listed below.**

☐ 2 X 2 Photo	☐ Criminal Conviction Documentation	☐ Fingerprint Cards x 2 (or)
☐ $25 Processing Fee	☐ Certification forms from each state of licensure	☐ Live Scan Form
☐ $250 Application Fee	☐ $56 Criminal Record Check Fee	☐ Facility Employer Section Completed (17)

I declare under penalty of perjury under the laws of the State of California that the information furnished in this application is true and correct. By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct, and that the photograph attached hereto is a true likeness of myself. I hereby authorize the State of California to verify any and all information contained in this application, including information maintained in applicable data banks, and to transmit this information to the licensing authority of the state to which this application is made. I authorize the licensing authority of the State of California to review state files pertaining to my licensure and practice, and all law enforcement records, administrative records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the licensing authority.

APPLICANT'S SIGNATURE _____	**DATE** / /

NHAP PROVISIONAL LICENSE APPLICATION CERTIFICATION

TO THE APPLICANT:
If you are applying for the CA NHA Provisional License on the basis of your licensure in another state, please have the following certification completed by the licensing board of the state in which you are currently licensed and all other states in which you have ever held a license as a nursing home administrator. (Duplication of this page is permitted)

TO THE STATE BOARD, PROGRAM OR LICENSING AGENCY IN WHICH THE BELOW NAMED APPLICANT IS OR EVER HAS BEEN LICENSED.

_____ is applying for licensure as a nursing home administrator in California. Please furnish the following information concerning the applicant.
(Name)

APPLICANT'S NAME (AS SHOWN ON YOUR RECORDS)

DATE OF BIRTH	SOCIAL SECURITY NUMBER	
ORIGINAL LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE

1. Has the licensee ever had any application for any professional license refused or denied by your licensing authority?	☐ **YES** ☐ **NO**
2. Has the licensee ever been refused or denied the privilege of taking an examination required for any professional licensure?	☐ **YES** ☐ **NO**
3. Has the licensee ever been dropped, suspended, placed on probation, fined or requested to resign license in lieu of adverse action by your states licensing authority?	☐ **YES** ☐ **NO**
If **YES**, list offense, duration of discipline, discipline type, date(s) of discipline, and completion date(s). _____ _____	
4. Has the applicants NHA license ever been revoked?	☐ **YES** ☐ **NO**
5. Has the licensee ever been the subject of disciplinary action with regard to your states NHA license, been sanctioned by any other licensing authority, association, licensed facility, or staff of such facility?	☐ **YES** ☐ **NO**
6. Are there any unresolved or pending complaints against the licensee with any licensing agency in your state?	☐ **YES** ☐ **NO**
Length of time needed to resolve these? _____.	
7. The number, type, and date(s) of complaints filed against licensee: _____. _____.	
8. Does the applicant comply with your states regulatory requirements governing long-term care administrators or facilities?	☐ **YES** ☐ **NO**
9. Were any citations issued against the licensee? Number of citations that were upheld against the licensee _____. Citation level (AA, A, B, etc.) _____.	☐ **YES** ☐ **NO**
10. Candidate's National Examination score _____.	
11. Did licensee complete an Administrator-in-Training Program in your state?	☐ **YES** ☐ **NO**
If **YES**, number of hours completed: _____.	
12. What is/was the licensee's length of time licensed in your state?	
13. Is the licensee a preceptor in your state?	☐ **YES** ☐ **NO**
14. Is the licensee's Continuing Education current?	☐ **YES** ☐ **NO**

SIGNATURE OF EXECUTIVE OFFICER OR DIRECTOR	DATE SIGNED

NAME OF EXECUTIVE OFFICER (PLEASE PRINT OR TYPE)

AGENCY

ADDRESS (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

TELEPHONE NUMBER	FAX NUMBER
WEBSITE	E-MAIL ADDRESS

STATE BOARD: PLEASE RETURN THIS COMPLETED FORM DIRECTLY TO THE : NURSING HOME ADMINISTRATOR PROGRAM.
P.O. BOX 997416, MS 3302
SACRAMENTO, CA 95899-7416

PLACE SEAL HERE

NHAP PROVISIONAL LICENSE APPLICATION

(For Statistical Use Only)

APPLICANT: To assist NHAP in creating applicant statistical information, applicants are asked to voluntarily provide the following information. This questionnaire will be separated from the application prior to its review and will be kept confidential. Government Code Section 19705 authorizes the State to retain this information for research and statistical purposes.

AGE	GENDER
☐ (1) UNDER 21 ☐ (3) 21 - 39 ☐ (6) 40 - 69 ☐ (7) 70 AND OVER	☐ MALE ☐ FEMALE

Ethnic Category *(Please check the box that best describes your race/ethnicity.):*

☐ (7) **AMERICAN INDIAN OR ALASKAN NATIVE--**Persons having origins in any of the tribal peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

☐ (2) **ASIAN--**Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent. This includes China, Japan, and Korea.

☐ (1) **AFRICAN AMERICAN--**Persons having origins in any of the black racial groups.

☐ (8) **FILIPINO--**Persons having origins in any of the original peoples of the Philippine Islands.

☐ (4) **HISPANIC--**Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

☐ (6) **PACIFIC ISLANDERS--**Persons having origins in the Pacific Islands, such as Samoa.

☐ (5) **CAUCASIAN--**Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Check if:

☐ (3) **OTHER** *(Specify)* _____

☐ (Y) **DISABLED—**A person with a disability is an individual who: (1) has a physical or mental impairment that substantially limits one or more life activities, such as walking, speaking, breathing, performing manual tasks, seeing, hearing, learning, caring for oneself or working; (2) has a record of such an impairment; (3) is regarded as having such an impairment.

☐ **MILITARY--**A military veteran; a widow or widower of a veteran; or a spouse of a 100% disabled veteran.

Why did you apply for a Provisional License in California?

☐ RECRUITED TO WORK IN STATE. ☐ RELOCATING TO STATE ☐ TEMPORARY FACILITY MANAGER

☐ OWN A NURSING HOME ☐ OTHER _____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE